		FOR OHF USE					

LL1

2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0038679

Facility Name: Park Haven Manor

Address: 107 S. Lincoln (Number) Smithton (City) 62285 (Zip Code)

County: Saint Clair

Telephone Number: (618) 235-4600 **Fax #** (618) 235-5829

IDPA ID Number: 95-2301514017

Date of Initial License for Current Owners: 12/31/1985

Type of Ownership:

	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code		X	Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Greg LeRoy **Telephone Number:** (479) 201-4371

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2004 to 12/31/2004 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ 03/31/2005 (Date)
(Type or Print Name) Greg Swartz
(Title) Assistant Secretary

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title) _____
(Firm Name & Address) _____
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Park Haven Manor # 0038679 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	101	Intermediate (ICF)	101	36,865	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	101	TOTALS	101	36,865	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF		1,103		1,103	8
9	SNF/PED					9
10	ICF	26,858			26,858	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	26,858	1,103		27,961	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 75.85%

D. How many bed-hold days during this year were paid by Public Aid?
21 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 12/31/1985

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 12/31/1985 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified 0 and days of care provided 0

Medicare Intermediary United Government Services

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2004 Fiscal Year: 12/31/2004

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Park Haven Manor # 0038679 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	115,271	6,571	2,018	123,860		123,860	4,991	128,851			1
2	Food Purchase		105,333		105,333		105,333	(1,079)	104,254			2
3	Housekeeping	952	672	74,801	76,425		76,425	945	77,370			3
4	Laundry		2,485	49,255	51,740		51,740	(608)	51,132			4
5	Heat and Other Utilities			66,724	66,724		66,724	(235)	66,489			5
6	Maintenance	34,357	12,857	22,647	69,861		69,861	2,361	72,222			6
7	Other (specify):*			619	619		619	60	679			7
8	**TOTAL General Services**	150,580	127,918	216,064	494,562		494,562	6,435	500,997			8
	B. Health Care and Programs											
9	Medical Director			3,600	3,600		3,600		3,600			9
10	Nursing and Medical Records	799,092	26,618	37,269	862,979	(450)	862,529	22,852	885,381			10
10a	Therapy		92		92		92		92			10a
11	Activities	22,337	5,395	554	28,286		28,286	(582)	27,704			11
12	Social Services	139,927	2,217	4,438	146,582		146,582	3,378	149,960			12
13	Nurse Aide Training			(4,404)	(4,404)	450	(3,954)	4,404	450			13
14	Program Transportation			7,333	7,333		7,333	56	7,389			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	961,356	34,322	48,790	1,044,468		1,044,468	30,108	1,074,576			16
	C. General Administration											
17	Administrative			242,730	242,730	82,245	324,975	27,719	352,694			17
18	Directors Fees											18
19	Professional Services			820	820		820		820			19
20	Dues, Fees, Subscriptions & Promotions			27,355	27,355		27,355	(2,154)	25,201			20
21	Clerical & General Office Expenses	131,855	6,073	71,127	209,055	(82,245)	126,810	(2,653)	124,157			21
22	Employee Benefits & Payroll Taxes			235,104	235,104		235,104	(1,542)	233,562			22
23	Inservice Training & Education			1,905	1,905		1,905	284	2,189			23
24	Travel and Seminar			4,496	4,496		4,496	(1,273)	3,223			24
25	Other Admin. Staff Transportation			1,423	1,423		1,423		1,423			25
26	Insurance-Prop.Liab.Malpractice			75,956	75,956		75,956	119,803	195,759			26
27	Other (specify):*			(3,205)	(3,205)		(3,205)	3,205				27
28	**TOTAL General Administration**	131,855	6,073	657,711	795,639		795,639	143,389	939,028			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,243,791	168,313	922,565	2,334,669		2,334,669	179,932	2,514,601			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Park Haven Manor #0038679 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			46,152	46,152		46,152	(3,510)	42,642			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			23	23		23		23			32
33	Real Estate Taxes			43,330	43,330		43,330	4,310	47,640			33
34	Rent-Facility & Grounds			189,139	189,139		189,139		189,139			34
35	Rent-Equipment & Vehicles			21,687	21,687		21,687	(3,558)	18,129			35
36	Other (specify):*			30,509	30,509		30,509		30,509			36
37	**TOTAL Ownership**			330,840	330,840		330,840	(2,758)	328,082			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		11,750		11,750		11,750	(11,750)				39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee							56,068	56,068			42
43	Other (specify):*		4,197		4,197		4,197	(4,197)				43
44	**TOTAL Special Cost Centers**		15,947		15,947		15,947	40,121	56,068			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,243,791	184,260	1,253,405	2,681,456		2,681,456	217,295	2,898,751			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Park Haven Manor # 0038679 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,124)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(21)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	3,250	27		18
19	Entertainment				19
20	Contributions	(444)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(15,479)	21		24
25	Fund Raising, Advertising and Promotional	(3,366)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(176)	20		28
29	Other-Attach Schedule	43,418			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ 26,058		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	36,106	17	34
35	Other- Attach Schedule	155,131		35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 191,237		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 217,295		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Park Haven Manor

ID# 0038679

Report Period Beginning: 01/01/2004

Ending: 12/31/2004

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Park Haven Manor **#** 0038679 **Report Period Beginning:** 01/01/2004 **Ending:** 12/31/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
1	Dietary	4,991	0	0	0	0	0	0	0	0	0	0	4,991	1
2	Food Purchase	(1,079)	0	0	0	0	0	0	0	0	0	0	(1,079)	2
3	Housekeeping	945	0	0	0	0	0	0	0	0	0	0	945	3
4	Laundry	(608)	0	0	0	0	0	0	0	0	0	0	(608)	4
5	Heat and Other Utilities	(235)	0	0	0	0	0	0	0	0	0	0	(235)	5
6	Maintenance	2,361	0	0	0	0	0	0	0	0	0	0	2,361	6
7	Other (specify):*	60	0	0	0	0	0	0	0	0	0	0	60	7
8	**TOTAL General Services**	6,435	0	0	0	0	0	0	0	0	0	0	6,435	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	22,852	0	0	0	0	0	0	0	0	0	0	22,852	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(582)	0	0	0	0	0	0	0	0	0	0	(582)	11
12	Social Services	3,378	0	0	0	0	0	0	0	0	0	0	3,378	12
13	Nurse Aide Training	4,404	0	0	0	0	0	0	0	0	0	0	4,404	13
14	Program Transportation	56	0	0	0	0	0	0	0	0	0	0	56	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	30,108	0	0	0	0	0	0	0	0	0	0	30,108	16
	C. General Administration													
17	Administrative	27,719	0	0	0	0	0	0	0	0	0	0	27,719	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(2,154)	0	0	0	0	0	0	0	0	0	0	(2,154)	20
21	Clerical & General Office Expenses	(2,653)	0	0	0	0	0	0	0	0	0	0	(2,653)	21
22	Employee Benefits & Payroll Taxes	(1,542)	0	0	0	0	0	0	0	0	0	0	(1,542)	22
23	Inservice Training & Education	284	0	0	0	0	0	0	0	0	0	0	284	23
24	Travel and Seminar	(1,273)	0	0	0	0	0	0	0	0	0	0	(1,273)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	119,803	0	0	0	0	0	0	0	0	0	0	119,803	26
27	Other (specify):*	3,205	0	0	0	0	0	0	0	0	0	0	3,205	27
28	**TOTAL General Administration**	143,389	0	0	0	0	0	0	0	0	0	0	143,389	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	179,932	0	0	0	0	0	0	0	0	0	0	179,932	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Park Haven Manor # 0038679 **Report Period Beginning:** 01/01/2004 **Ending:** 12/31/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(3,510)	0	0	0	0	0	0	0	0	0	0	(3,510)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	4,310	0	0	0	0	0	0	0	0	0	0	4,310	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	(3,558)	0	0	0	0	0	0	0	0	0	0	(3,558)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(2,758)	0	0	0	0	0	0	0	0	0	0	(2,758)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	(11,750)	0	0	0	0	0	0	0	0	0	0	(11,750)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	56,068	0	0	0	0	0	0	0	0	0	0	56,068	42
43	Other (specify):*	(4,197)	0	0	0	0	0	0	0	0	0	0	(4,197)	43
44	**TOTAL Special Cost Centers**	40,121	0	0	0	0	0	0	0	0	0	0	40,121	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	217,295	0	0	0	0	0	0	0	0	0	0	217,295	45

Facility Name & ID Number Park Haven Manor # 0038679 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Beverly Health & Rehabilitation Services	100	More than 340 facilities throughout the U.S.		Aegis Therapies, Inc.	Fort Smith, AR	Therapy
				Ceres Stategies, Inc.	Fort Smith, AR	Purchasing
				AEDON Staffing, Inc.	Fort Smith, AR	Nursing Staffing
				CSMS, Inc.	Fort Smith, AR	Purchasing

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	Home Office Costs	$ 242,682	Beverly Health & Rehabilitation Services	100.00%	$ 267,344	$ 24,662	1
2	V	10	Nursing Consultant	32,904	Beverly Health & Rehabilitation Services	100.00%	39,429	6,525	2
3	V	01	Dietary Consultant	0	Beverly Health & Rehabilitation Services	100.00%	1,627	1,627	3
4	V	12	Housekeeping Consultant	0	Beverly Health & Rehabilitation Services	100.00%	907	907	4
5	V								5
6	V	10a	Therapy Expense/Home Office	0	Aegis Therapies, Inc.	100.00%	0		6
7	V	27	Home Office Costs	0	Ceres Strategies, Inc.	100.00%	2,385	2,385	7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 275,586			$ 311,692	$ * 36,106	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Park Haven Manor # 0038679 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

*** If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.**

**** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION**

Facility Name & ID Number Park Haven Manor # 0038679 Report Period Beginning: 01/01/2004 Ending: 2/31/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Beverly Health & Rehabilitation Services
Street Address: One Thousand Beverly Way
City / State / Zip Code: Fort Smith, AR 72919
Phone Number: (479) 201-2000
Fax Number: (479) 201-4302

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	Corp Home Office/Admin	Resident Days	83,073	3	$ 793,730	$ 392,807	27,982	$ 267,357	1
2										2
3										3
4	10	Corp QA Cost - Nursing	Resident Days	83,073	3	117,031	95,497	27,982	39,420	4
5										5
6	01	Corp QA Cost - Dietary	Resident Days	83,073	3	4,832	3,697	27,982	1,628	6
7										7
8	12	Corp QA Cost - Housekeeping	Resident Days	83,073	3	2,684	1,681	27,982	904	8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24		ROUNDING							(2)	24
25	TOTALS					$ 918,277	$ 493,682		$ 309,307	25

Facility Name & ID Number Park Haven Manor # 0038679 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Non-Care Related Interest		X	Working Capital							23	6
7												7
8												8
9	TOTAL Facility Related						$	$			$ 23	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$ 23	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 11,691 Line # 34

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Park Haven Manor # 0038679 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2003 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	24,101	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	47,640	2
3. Under or (over) accrual (line 2 minus line 1).	$	23,539	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)	$	24,101	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	47,640	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1999	39,397	8
	2000	42,505	9
	2001	44,459	10
	2002	46,565	11
	2003	47,640	12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Park Haven Manor COUNTY Saint Clair

FACILITY IDPH LICENSE NUMBER 0038679

CONTACT PERSON REGARDING THIS REPORT Greg LeRoy

TELEPHONE (479) 201-4371 FAX #: (479) 201-4302

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	13-33.0-113-004	Encore Park Haven IL LLC	$ 47,640.00	$ 47,640.00
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 47,640.00	$ 47,640.00

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

Facility Name & ID Number Park Haven Manor # 0038679 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 21,282 B. General Construction Type: Exterior Brick Frame Wood Number of Stories One

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [ ] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		1985	$	1
2					2
3	TOTALS			$	3

Facility Name & ID Number Park Haven Manor # 0038679 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	101		1985		$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10	LEASEHOLD IMPROVEMENTS			1993	52,443	483	5-20	483		50,424	10
11	(See depreciation schedule for asset detail of items acquired 1993 - 2000)			1994	27,057	394	5-20	394		26,057	11
12				1995	13,241	805	5-20	805		9,068	12
13				1996	2,711	198	5-20	198		1,614	13
14				1997	100,410	8,927	5-20	8,927		66,258	14
15				1998	20,749	1,245	5-20	1,245		7,919	15
16				1999	8,584	807	5-20	807		4,837	16
17				2000	8,561	605	5-20	605		2,731	17
18											18
19	INST'L OF WATER HEATER			2001	1,452	145	10	145		581	19
20	DEPOSIT:2 DOORS			2001	600	60	10	60		215	20
21	ROOF REPAIR			2001	57,038	5,704	10	5,704		19,963	21
22	CONSTRUCTION INTEREST			2001	27	3	10	3		9	22
23	DEPOSIT:REPL 5 WINDOWS			2001	1,182	118	10	118		404	23
24	BAL DUE:REPL 5 WINDOWS			2001	1,185	118	10	118		385	24
25	REPL DOORS			2001	1,767	177	10	177		545	25
26											26
27											27
28											28
29	REPL COMPRESSOR-ROOFTOP AC			2002	943	63	15	63		168	29
30	WALK IN COOLER/FREEZER			2002	8,776	585	15	585		1,560	30
31	KEYPAD			2002	600	40	15	40		103	31
32	3 DROPS			2002	970	65	15	65		162	32
33	CONTRUCTION INTEREST			2002	103	7	15	7		17	33
34	FIXED EQUIPMENT-15 YEAR LIFE			2002	22,089	1,473	15	1,473		3,682	34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Park Haven Manor # 0038679 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	CONTRACTOR PAY REQUESTS	2003	$ 48,533	$ 3,236	15	$ 3,236	$	$ 5,932	37
38	REPL CONDENSING COIL/HVAC	2003	945	63	15	63		89	38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46	PRIVACY FENCE W/GATES,LIGH	2004	5,941	619	8	619		619	46
47	WM ALARM PANEL, INSTALL	2004	3,511	205	10	205		205	47
48	HEAT PUMP, AIR HANDLER,INS	2004	5,250	263	10	263		263	48
49	15 VANITY CABINETS & TOPS	2004	2,052	57	15	57		57	49
50	OUTLETS,BREAKER/CARE TRACK	2004	2,342	39	20	39		39	50
51	GARBAGE DISPOSAL,INSTALL	2004	1,024	68	5	68		68	51
52	ARCHITECTURAL FEES	2004							52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 400,086	$ 26,570		$ 26,570	$	$ 203,972	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Park Haven Manor # 0038679 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 194,006	$ 15,531	$ 15,531	$	5-10	$ 127,516	71
72	Current Year Purchases	12,659	540	540		5-10	540	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 206,665	$ 16,071	$ 16,071	$		$ 128,056	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 606,751	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 42,642	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 42,642	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 332,028	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92	Facility Renovation	$ 2,820	92
93			93
94			94
95		$ 2,820	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Encore Retirement Centers, Inc.
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		101	12/31/1985	$ 189,139	5	30	3
4	Additions							4
5								5
6								6
7	TOTAL		101		$ 189,139 **			7

10. Effective dates of current rental agreement:
    Beginning 12/31/2001
    Ending 12/31/2006

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	12/31/05	$ 199,464
13.	12/31/06	$ 199,464
14.		$

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: [X] YES [ ] NO Terms: Purchase of all Encore facilities *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO
16. Rental Amount for movable equipment: $ Description: See attached schedule
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Facility	2000 Ford Windstar	$ 406.58	$ 4,879	17
18					18
19					19
20					20
21	TOTAL		$ 406.58	$ 4,879	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Park Haven Manor # 0038679 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [X]
- HOURS PER AIDE 90

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [X]
- HOURS PER AIDE 39

B. EXPENSES

ALLOCATION OF COSTS (d)

			1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition		$	$ 410	$	$ 410
2	Books and Supplies			40		40
3	Classroom Wages	(a)				
4	Clinical Wages	(b)				
5	In-House Trainer Wages	(c)				
6	Transportation					
7	Contractual Payments					
8	Nurse Aide Competency Tests					
9	TOTALS		$	$ 450	$	$ 450
10	SUM OF line 9, col. 1 and 2	(e)	$ 450			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	1
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	1

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Park Haven Manor # 0038679 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2004 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 1,509	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 6,374)	445,314		3
4	Supply Inventory (priced at Historical Cost)	24,078		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	28,851		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 499,752	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable	106,593		11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	2,820		14
15	Leasehold Improvements, at Historical Cost	400,086		15
16	Equipment, at Historical Cost	206,665		16
17	Accumulated Depreciation (book methods)	(332,028)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 384,136	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 883,888	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 54,516	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	70,213		30
31	Accrued Taxes Payable (excluding real estate taxes)	6,766		31
32	Accrued Real Estate Taxes(Sch.IX-B)	26,051		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Contingencies			36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 157,546	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Intercompany	713,172		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 713,172	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 870,718	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 13,170	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 883,888	$	48

***(See instructions.)**

Facility Name & ID Number Park Haven Manor # 0038679 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 591,113	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 591,113	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(577,943)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (577,943)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 13,170	24 *

*** This must agree with page 17, line 47.**

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XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,157,892	1
2	Discounts and Allowances for all Levels	(56,617)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,101,275	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	1,124	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,124	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Net Vending, Pat Pers Needs, Other Misc. Rev	1,114	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,114	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,103,513	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	494,562	31
32	Health Care	1,044,468	32
33	General Administration	795,639	33
	B. Capital Expense		
34	Ownership	330,840	34
	C. Ancillary Expense		
35	Special Cost Centers	(40,121)	35
36	Provider Participation Fee	56,068	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,681,456	40
41	**Income before Income Taxes (line 30 minus line 40)****	(577,943)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (577,943)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

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XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,006	2,118	$ 59,443	$ 28.06	1
2	Assistant Director of Nursing	1,596	1,676	39,553	23.60	2
3	Registered Nurses	3,301	3,525	75,569	21.44	3
4	Licensed Practical Nurses	12,697	13,502	210,643	15.60	4
5	Nurse Aides & Orderlies	32,260	34,760	305,976	8.80	5
6	Nurse Aide Trainees	0	0	0		6
7	Licensed Therapist	0	0	0		7
8	Rehab/Therapy Aides	0	0	0		8
9	Activity Director	2,023	2,086	22,736	10.90	9
10	Activity Assistants	199	202	1,480	7.32	10
11	Social Service Workers	9,922	10,821	140,506	12.98	11
12	Dietician	0	280	5,923	21.17	12
13	Food Service Supervisor	0	0	0		13
14	Head Cook	0	0	0		14
15	Cook Helpers/Assistants	13,307	14,216	109,423	7.70	15
16	Dishwashers	0	0	0		16
17	Maintenance Workers	1,977	2,996	35,290	11.78	17
18	Housekeepers	0	0	0		18
19	Laundry	0	0	0		19
20	Administrator	1,783	2,469	82,245	33.31	20
21	Assistant Administrator	0	0	0		21
22	Other Administrative	6,035	5,492	59,167	10.77	22
23	Office Manager	0	0	0		23
24	Clerical	0	0	0		24
25	Vocational Instruction	0	0	0		25
26	Academic Instruction	0	0	0		26
27	Medical Director	0	0	0		27
28	Qualified MR Prof. (QMRP)	0	0	0		28
29	Resident Services Coordinator	0	0	0		29
30	Habilitation Aides (DD Homes)	0	0	0		30
31	Medical Records	3,368	3,711	48,932	13.18	31
32	Other Health C: MDS Coordinator	2,088	2,319	46,905	20.22	32
33	Other(specify) DSD Cooridnator	0	0	0		33
34	TOTAL (lines 1 - 33)	92,563	100,176	$ 1,243,791 *	$ 12.42	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$ 1,991	1-3	35
36	Medical Director		3,600	9-3	36
37	Medical Records Consultant		0	10-3	37
38	Nurse Consultant		280	10-3	38
39	Pharmacist Consultant		3,250	10-3	39
40	Physical Therapy Consultant		0	N/A	40
41	Occupational Therapy Consultant		0	N/A	41
42	Respiratory Therapy Consultant		0	N/A	42
43	Speech Therapy Consultant		0	N/A	43
44	Activity Consultant		535	11-3	44
45	Social Service Consultant		4,379	12-3	45
46	Other(specify) Hskpg/Laundry		124,057	3,4	46
47	Maintenance		17,627	6	47
48	Profess,MedWaste, Transport		480	6,19	48
49	TOTAL (lines 35 - 48)		$ 156,199		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	0	$ 0		50
51	Licensed Practical Nurses	0	0		51
52	Nurse Aides	0	0		52
53	TOTAL (lines 50 - 52)		$		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
REBECCA GARCIA	Executive Director	0	$ 9,960
MELVIN ZIMMERMAN	Executive Director	0	72,285
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 82,245

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Corporation Service Co. Inc.	Legal	$ 0
HR Solutions	Human Resource	340
Deloitte & Touche, LLP.	Accounting	480
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 820

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 26,989
Unemployment Compensation Insurance	0
FICA Taxes	0
Employee Health Insurance	82,709
Employee Meals	0
Illinois Municipal Retirement Fund (IMRF)*	0
Employee Injury	0
Payroll Taxes	118,481
Retirement Expense	0
Employee Fringe Benefits	5,383
Rounding	0
TOTAL (agree to Schedule V, line 22, col.8)	$ 233,562

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 2,178
Advertising: Employee Recruitment	5,461
Health Care Worker Background Check	828
(Indicate # of checks performed 0)	
Dues, Subscriptions, & License	13,360
Advertising and Public Relations	5,912
Community Education	0
Contributions	444
Reclass Miscoded Expense	0
Less: PAC Fees/Contributions	
Less: Public Relations Expense	( )
Non-allowable advertising	(2,982)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 25,201

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	2,200
Meals	1,023
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,223

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Park Haven Manor # 0038679 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Park Haven Manor # 0038679 **Report Period Beginning:** 01/01/2004 **Ending:** 12/31/2004

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Illinois Health Care Association** **$5,535**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **Various**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **200** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **56,068**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **N/A** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **1,124**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **50%**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Ernst & Young, LLP** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **No** If no, please explain. **Beverly is a publicly traded company**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **No**
Attach invoices and a summary of services for all architect and appraisal fees.